

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 99.0

## CERTIFICATE OF DEATH

03846

Reg. Dist. No. 92

## 1. PLACE OF DEATH:

County Cecil

City or town Elkton, Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 weeks

Hospital, institution, or street address where death occurred:

Union Hospital

How long in hospital or institution? 2 weeks

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Cecil

City or town Elk Mills, Md.  
(If outside city or town limits, write RURAL and give nearest town)Street No.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Charles August Arndt

## 3. (b) Social Security Number

4. Sex

M.

5. Color or race

Wh

6.(a) Single, married, widowed, or divorced

?

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

7 50

hra.

min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER  
MOTHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial  
(Burial, cremation, or removal. Which?)Date thereof April 16/45  
(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. Apr 16 1945  
(Date rec'd by registrar)FR Frazier  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 6 1945 at 9:15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 5 1945 to April 6 1945 and that I last saw him alive on April 5 1945

Immediate cause of death

myocardial infarction

DURATION

3 months

Due to

Due to

Other conditions

abdominal aortic aneurysm

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Dr. Fred H. Sprecher MD

M. D. or other

Address Elkton, Md. Date signed April 16

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

IN THE DISTRICT OF COLUMBIA

STATE OF MARYLAND

DEPARTMENT OF HEALTH

RECEIVED  
APR 23 1945  
BUREAU V.S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03847

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

## 1. PLACE OF DEATH:

County.....

City or town..... **BAINBRIDGE, MARYLAND**  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... **Texas**..... County..... **Terry**.....City or town..... **Meadow**  
(If outside city or town limits, write RURAL and give nearest town)Street No..... **Route # 1**  
(If rural, give LOCATION)2.(a) If veteran, name war..... **WORLD WAR II**

## 3. (a) FULL NAME

**Ray (None) BROWN**

## 3. (b) Social Security Number

4. Sex

**Male**

5. Color or race

**Negro**

6.(a) Single, married, widowed, or divorced

**Single.**6.(b) Name of husband or wife..... **Not married**

7. Birth date of

deceased (mo., day, yr.) **July 21, 1927**

6.(c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

**17****8****13**

hrs.

min.

9. Birthplace..... **Bastrop, Texas**

(Town, county, and state)

10. Usual occupation.....

**Unknown**

11. Industry or business

**US Navy**

FATHER

12. Name.....

**Unknown**

13. Birthplace

**Unknown**

MOTHER

14. Maiden name.....

**Unknown**

15. Birthplace

**Unknown**

16. Informant

**US Naval Hospital, NavTra Cen**

Address

**BAINBRIDGE MARYLAND**

17.

(Burial, cremation, or removal. Which?)

Date thereof

**Apr 7, 1945**  
(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19.

**Apr 20, 1945**  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... **4 April, 1945**..... 19..... at **6:30P M**

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

**31 March, 1945**..... 19..... to **4 April, 1945**..... 19.....and that I last saw him..... alive on **4 April, 1945**..... 19.....

Immediate cause of death

**POISONING**

DURATION

**7 days**Due to..... **PROPHYLACTIC SULFADIAZINE**

Due to.....

Other conditions..... **PNEUMONIA, HEMORRHAGIC****2 days**

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results..... **AS ABOVE**

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?.....  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE.....

**Harry C. Oard, MD**

US Naval Hosp. NavTra Cen Bainbridge, Md.

Address..... Date signed..... **4/4/45**

MARGIN RESERVED FOR BINDING

VS A16

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

RECEIVED

APR 21 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(121)

03848

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

## 1. PLACE OF DEATH:

County..... Cecil  
 City or town..... Elkton  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 17 days  
 Hospital, institution, or street address where death occurred:  
Union Hospital  
 How long in hospital or institution?..... 17 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... Maryland County..... Cecil  
 City or town..... Charlestown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Theodore Cather

## 3. (b) Social Security Number

4. Sex..... male 5. Color or race..... white 6.(a) Single, married, widowed, or divorced..... married  
 8.(b) Name of husband or wife..... Clara B Cather  
 6.(c) If alive, give age..... 45 years  
 7. Birth date of deceased (mo., day, yr.)..... May 20 1889  
 8. AGE: Years..... 55 Months..... 10 Days..... 20 If less than one day..... hrs. .... min.

9. Birthplace..... Penna.  
 (Town, county, and state)  
 10. Usual occupation..... store keeper  
 11. Industry or business..... Owner  
 12. Name..... Samuel Cather  
 13. Birthplace..... Cecil Co., Md.  
 14. Maiden name..... Mary Physick  
 15. Birthplace..... Cecil Co., Md.

18. Informant..... Clara B. Cather  
 Address..... Charlestown, Md.  
 17. Burial..... Burial Date thereof..... April 12, 1945  
 (Burial, cremation, or removal. Watch!) (month) (day) (year)  
 Cemetery or crematory..... Charlestown, Md.  
 Location..... Charlestown, Md.  
 18. Funeral director..... W. A. Patterson & Son  
 Address..... Berryville, Md.  
 19. April 12, 1945..... FR Frazier  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Apr. 9, 1945 at 1 1/2 P. M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... 19....., to..... 19.....  
 and that I last saw him alive on..... Apr. 9, 1945  
 Immediate cause of death..... Coronary thrombosis  
 DURATION..... 24 hrs.  
 Due to.....  
 Due to..... Suppuration of appendix  
 Other conditions.....  
 (Include pregnancy within 3 months of death)  
 Major findings of operation..... Abdominal ulcers  
Wandering ulcers Date of op. .... Mar. 30, 1945  
 Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?..... (City or town)..... (County)..... (State).....  
 Injured at home, farm, industry, public place (where?).....  
 Means of injury..... Injured at work?.....  
 23. SIGNATURE..... W. A. Patterson M. D. co-witness.....  
 Address..... North East, Md. Date signed..... 4/9/45

CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. PLACE OF DEATH

3. MEDICAL EXAMINER

RECEIVED  
APR 17 1945

4. SIGNATURE OF DECEASED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

03849

Reg. Dist. No. 91

1. PLACE OF DEATH: Cecil  
 County.....  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 37 yrs  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State.....  
 County.....  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2.(c) If veteran, name war.....

3. (a) FULL NAME *Julius White Clayton*

3. (b) Social Security Number

169-20-1494

4. Sex *Male* 5. Color or race *White* 6. (a) Single, married, widowed, or divorced *married*  
 6. (b) Name of husband or wife *Mary Ellison Clayton*  
 7. Birth date of deceased (mo., day, yr.) *Apr 1 1874* 6. (c) If alive, give age *71* years  
 8. AGE: Years *71* Months Days If less than one day  
 hrs. min.

9. Birthplace *Mt Pleasant Delaware*  
 (Town, county, and state)

10. Usual occupation *Government retired*

11. Industry or business

12. Name *Joshua Clayton Jr*  
 13. Birthplace *Mt Pleasant Delaware*

14. Maiden name *Lavinia Moyer*  
 15. Birthplace *Roxbury Pa*

18. Informant *Mrs Mary Clayton*  
 Address *Chesapeake City Md*

17. Burial *Burial* Date thereof *Apr 24 1945*  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory *Bethel Cemetery*  
 Location *Chesapeake City Md R D*

18. Funeral director *H. W. Whipple*  
 Address *Elkton, Maryland*

19. *April 23rd* 19 *45* *Mrs Ralph D. Bell*  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH *April 22* 19 *45* at *2:20* A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *October 10* 19 *39*, to *April 22* 19 *45*, and that I last saw him alive on *April 22* 19 *45*.

Immediate cause of death *Coronary Thrombosis* DURATION *6 hours*

Due to *chronic myocarditis* *5 years*

Due to.....  
 Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations..... Date of op.....

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE *Thos Davis MD* M. D. or other  
 Address *Chesapeake City Md* Date signed *4/25/45*

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APR 26 1945

BUREAU V.S.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

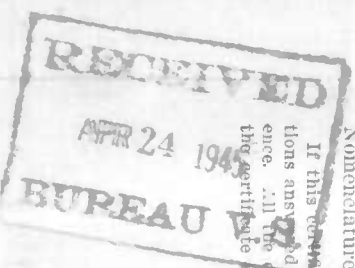
(Approved by U. S. Census and American Public Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*; *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonium*, etc., *Carcinoma*, *Sarcoma*, etc., ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mucositis*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropy," "Extinction," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is locked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for addition of date of death is shown on

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03851

FILM G 97 AUG 17 1945

## CERTIFICATE OF DEATH

Reg. Dist. No. 95

### 1. PLACE OF DEATH

County Cecil

City or town Epton  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 days

Hospital, institution, or street address where death occurred:

Union Hospital

How long in hospital or institution? 7 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Cecil

City or town Rising Sun  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1/4 mi north-west of Principis  
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

William Cowan

### 3. (b) Social Security Number

None

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

male white widowed

6.(b) Name of husband or wife Angie Cowan

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 2, 1870

8. AGE: Years 74 Months 9 Days 10 If less than one day hrs. min.

9. Birthplace Merdo, Va.  
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Farm

12. Name Richard Cowan

13. Birthplace

14. Maiden name Rodia Goppel

15. Birthplace

16. Informant Mrs Sherman Gilbert

Address Rising Sun, Md.

17. Burial Date thereof 4-15-1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Brave Side Cemetery

Location Epton, Illinois

18. Funeral director Ralph McReel

Address Rising Sun, Md.

19. Date of death 4-12-45

20. Date of death 4-12-45

### MEDICAL CERTIFICATION

20. DATE OF DEATH April 12, 1945 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

3-31-1945 to 3-12-1945

and that I last saw him alive on 3-11-1945

Immediate cause of death Traumatic Injuries

DURATION

Due to

Due to

Other conditions Cellulitis of

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Date signed 4/13/45

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RECEIVED

RECEIVED

RECEIVED

RECEIVED  
APR 21 1945  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (6)

## CERTIFICATE OF DEATH

03852

Reg. Dist. No. 96

## 1. PLACE OF DEATH:

County Cecil  
 City or town Perry Point, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 15 years  
 Hospital, institution, or street address where death occurred:  
Veterans Administration, Perry Point, Md.  
Facility  
 How long in hospital or institution? 1 day

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Cecil  
 City or town Perry Point,  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. ....  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war ..... No

## 3. (a) FULL NAME

MABEL CHASE DEMENT

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Edward H. DeMont6. (c) If alive, give age 55 years7. Birth date of deceased (mo., day, yr.) November 3, 1890

8. AGE: Years 54 Months 7 Days 2 If less than one day  
 .... hrs. .... min.

9. Birthplace Tuppers Plains, Meigs Co. Ohio.  
(Town, county, and state)10. Usual occupation Housewife11. Industry or business -12. Name Frank C. Chase13. Birthplace Athens Co., Ohio14. Maiden name Maria Shields15. Birthplace Meigs Co. Ohio.16. Informant Edward H. DeMont (Husband)Address Veterans Administration, Perry Point, Md.17. Removal Date thereof 4-7-45  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory HumphreyLocation Coolville, Ohio18. Funeral director Lee Patterson & SonAddress 1414 N. Perryville, Md.19. April 7, 1945 John E. Rughley  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 5 19 45 at 9:55 p.m.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 4 19 45 to April 5 19 45and that I last saw him er alive on April 5 19 45Immediate cause of death Chronic Myocarditis with myocardial insufficiency DURATION Over 1 yr.Due to Chronic Myocarditis with myocardial insufficiencyDue to Chronic Myocarditis with myocardial insufficiencyOther conditions Diabetes Mellitus Over 3 mo.Obesity, Marked Over 1 yr.

(Include pregnancy within 3 months of death)

Major findings of operations NoneAutopsy results Not performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide - Date of -

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -Means of Injury - Injured at work? -23. SIGNATURE A.E. TROLLINGER

Clinical Director, Veterans Administration

Address Perry Point, Md. Date signed 1-8-45

CERTIFICATE OF DEATH

RECEIVED  
APR 21 1945  
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age is shown on

FILM No. G 95 MAY 28 1945

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

## CERTIFICATE OF DEATH

03853

96

Reg. Dist. No. ....

### 1. PLACE OF DEATH:

County... **CECIL**  
City or town... **VETERANS ADMINISTRATION, PERRY POINT, MD.**  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? ... **4 mo. 13 da.**

Hospital, institution, or street address where death occurred:  
**Veterans Administration, Perry Point, Md.**

How long in hospital or institution? ... **Same as above**

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State... **Va.** County... **Dinwiddie**

City or town... **Petersburg,**  
(If outside city or town limits, write RURAL and give nearest town)

Street No. ... **206 Lee Ave., Colonial Hts.**

(If rural, give LOCATION)

2(a) If veteran, name war ... **WW I**

### 3. (a) FULL NAME

**DIXON, William L.**

### 3. (b) Social Security Number

4. Sex **Male** 5. Color or race **White** 6. (a) Single, married, widowed, or divorced **Single**

6. (b) Name of husband or wife... **Single**

7. Birth date of deceased (mo., day, yr.) **February 27, 1896**

8. AGE: Years **49** Months **18** Days **13** It less than one day ... hrs. ... min.

9. Birthplace... **Wilton Co., N.C.**  
(Town, county, and state)

10. Usual occupation... **Merchant Marine**

11. Industry or business ...

12. Name... **Unknown**

13. Birthplace... **Unknown**

14. Maiden name... **Unknown**

15. Birthplace... **Unknown**

16. Informant... **Hospital Records**

Address... **Veterans Administration, Perry Point, Md.**

17. Removal... **Removal** Date thereof... **April 7, 1945**  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... **Arlington National Cemetery**

Location... **Arlington, Va.**

18. Funeral director... **Pennington & Son, Havre de Grace, Md.**

Address

19. **April 7, 1945** (Date rec'd by registrar) **Irma E. Dwyer** Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH... **April 5, 1945** at **6:00 A.M.**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **November 23, 1944** to **April 5, 1945**

and that I last saw him alive on **April 5, 1945**

Immediate cause of death... **Tuberculosis, pulmonary, chronic, far advanced, active** DURATION **over 5 yrs.**

Due to...

Due to...

Other conditions... **Psychosis, paranoid condition** over 2 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations... Date of op. ...

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... **W. J. Rosecrance** M. D. or other

Address... **Perry Point, Md.** Date signed... **4/6/45**

RECEIVED  
APR 21 1945  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1212

## CERTIFICATE OF DEATH

03854

Reg. Dist. No. 96

## 1. PLACE OF DEATH:

County Cecil  
 City or town Perry Point, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 yr. 6 mo. 20 da.  
 Hospital, institution, or street address where death occurred:  
Veterans Administration Facility, Perry Point, Md.  
 How long in hospital or institution? Same as above

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Pennsylvania County Butler  
 City or town Butler  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 419 S. Washington Street  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war W.W.I ✓

## 3. (a) FULL NAME

FARMER, Patrick

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single  
 6.(b) Name of husband or wife -  
 6.(c) If alive, give age - years  
 7. Birth date of deceased (mo., day, yr.) February 12, 1887  
 8. AGE: Years 58 Months 2 Days 10 If less than one day - hrs. - min.

9. Birthplace Irwin, Pa.  
 (Town, county, and state)  
 10. Usual occupation Miner  
 11. Industry or business -  
 12. Name John Farmer  
 13. Birthplace Scotland  
 14. Maiden name Jane Taylor  
 15. Birthplace Scotland

16. Informant Hospital Records  
 Address Veterans Administration, Perry Point, Md.

17. Removal ✓ Data thereof 4-24-45  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Baltimore National Cemetery  
 Location Baltimore, Md.

18. Funeral director Pennington & Son, Havre de Grace, Md.  
 Address -

19. April 24 19 45 John E. Langley  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 22 19 45, at 5:03 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 2, 19 43, to April 22, 19 45, and that I last saw him alive on April 22, 19 45.

Immediate cause of death Occlusion, Coronary, DURATION Unknown

Due to Other conditions: Arteriosclerosis, cerebral and general 1 yr. 9 mo.

Due to Hypertitis, chronic, arteriosclerotic 1 yr. 9 mo.

Other conditions Pneumonia, terminal Unknown

Psychosis with cerebral arteriosclerosis 1 yr. 9 mo.  
 (Include pregnancy within 8 months of death)

Major findings of operations - Date of op. -

Autopsy results Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide - Date of -

Where did injury occur? (City or town) - (County) - (State) -

Injured at home, farm, industry, public place (where?) -

Means of injury - Injured at work? -

23. SIGNATURE A. E. Tracing  
E. TROLLINGER, Lt. Col., M.C. Officer  
 Address Perry Point, Md. Date signed 4-23-45

CERTIFICATE OF DEATH

RECEIVED  
APR 26 1945  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 03855 90

1. PLACE OF DEATH: Cecil  
 County.....  
 City or town..... rural - Cecileton  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... life  
 Hospital, institution, or street address where death occurred:  
 .....  
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State..... Md County..... Cecil  
 City or town..... rural Cecileton  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war..... Spanish American

3. (a) FULL NAME William Evans Frazer. 3. (b) Social Security Number

4. Sex m 5. Color or race w 6.(a) Single, married, widowed, or divorced single

6.(b) Name of husband or wife.....

6.(c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.) March 15, 1874

8. AGE: Years 71 Months 29 Days hrs. min.

9. Birthplace..... Cecil County, Md  
 (Town, county, and state)

10. Usual occupation..... retired miller

11. Industry or business.....

12. Name..... Samuel Frazer

13. Birthplace..... New Castle County Del

14. Maiden name..... Annie Boulden

15. Birthplace..... New Castle County Del

16. Informant..... F. Rodney Frazer

Address..... Cecilton Md.

17. removal Date thereof April 16 '45  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Arlington

Location..... Arlington Va.

18. Funeral director..... H. W. Pippins

Address..... Cecilton Md.

19. April 16, 1945 Date rec'd by registrar

Joing Burke Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 13, 1945, at

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw him alive on 19

Immediate cause of death.....

Chronic Myocarditis

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... R. E. Dechouh

Address..... Pocomoke Md. M. D. or other

Date signed..... 4/14-45

Medical Examiner Cecil County

MAINTAIN STATE DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH

APR 24 1945  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

03856

Reg. Dist. No. 92

## 1. PLACE OF DEATH

County CecilCity or town Elkton  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Union Hospital

How long in hospital or institution?

## 3. (a) FULL NAME

Franklin Frederick Trach

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CecilCity or town Elkton  
(If outside city or town limits, write RURAL and give nearest town)Street No. 36 Hollingsworth House  
(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Single

## 6. (b) Name of husband or wife

6. (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 29-1945

## 8. AGE:

Years

Months

Days

If less than one day

6 hrs.30 min.9. Birthplace Elkton Cecil Maryland

(Town, county, and state)

## 10. Usual occupation

None

## 11. Industry or business

None

## FATHER

12. Name Leveath Walter Trach13. Birthplace Reading Pennsylvania

## MOTHER

14. Maiden name Blanche Hilda Lyell15. Birthplace North Carolina16. Informant Mrs. Blanche TrachAddress 36 Hollingsworth House Elkton Md17. Burial Date thereof May 2/45  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory ElktonLocation Elkton, Md18. Funeral director H W PippinAddress Elkton, Md19. May 2 19 45 FR Trach  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 30 19 45 at 2 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19....., to ..... 19.....

and that I last saw him ..... alive on ..... 19.....

Immediate cause of death

Pre-matureDue to infant5 1/2 monthsDue to gestation

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

..... Date of op. ....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Alfred Dodson MDAddress Wilmington Md M. D. or otherDate signed 4/30-45

CERTIFICATE OF DEATH

RECEIVED

MAY 9 1945

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13/a)

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

03857

## 1. PLACE OF DEATH:

County Cecil  
 City or town Veterans Administration, Perry Point, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 5 yrs. 4 days  
 Hospital, institution, or street address where death occurred:  
Veterans Administration Facility, Perry Point, Md.  
 How long in hospital or institution? Same as above

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. County -  
 City or town Washington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 3703 Quincy Street  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war Spanish American ✓

## 3.(a) FULL NAME

GLASCO, George R.

## 3.(b) Social Security Number

-

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Mrs. Margaret E. (Gorman)6.(c) If alive, give age ? years7. Birth date of deceased (mo., day, yr.) May 6, 1872

8. AGE: Years 72 Months 11 Days 16 If less than one day - hrs. - min.

9. Birthplace Washington, D.C.  
(Town, county, and state)10. Usual occupation Guard, Public Bldgs.11. Industry or business -

FATHER 12. Name John T. Glasco  
 13. Birthplace Washington, D.C.

MOTHER 14. Maiden name H.J. Shenig  
 15. Birthplace Governor's Island, N.Y.

16. Informant Hospital Records  
 Address Veterans Administration, Perry Point, Md.

17. Removal 4-22-45 Date thereof (month) (day) (year)  
 (Burial, cremation, or removal, Which?)  
 Cemetery or crematory Arlington National Cemetery  
 Location Arlington, Va.

18. Funeral director Pennington & Son  
 Address Havre de Grace, Md.

19. April 22 19 45 Irma E. Smyth Registrar  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 22 19 45 at 7:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 18 19 40 to April 22 19 45and that I last saw him alive on April 22 19 45

Immediate cause of death Ulcer of Stomach DURATION 5 yrs.

## Other Conditions:

Arteriosclerosis, cerebral 8 yrs.Arteriosclerosis, coronary 5 yrs.Thrombosis, cerebral 2 da.

Other conditions Nephritis, chronic, interstitial 5 yrs.

(Include pregnancy within 8 months of death)  
Psychosis with cerebral arteriosclerosis  
 Major findings of operations 5 yrs.

Date of op. -Autopsy results Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide - Date of -Where did injury occur? - (City or town) - (County) - (State)Injured at home, farm, industry, public place (where?) -Means of injury - Injured at work? -

23. SIGNATURE Irma E. Smyth M. D. or other  
 Clinical Director, Veterans Administration  
 Address Washington, D.C. Date signed April 22, 1945

RECEIVED  
APR 24 1965  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(121)

03858

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

## 1. PLACE OF DEATH:

County Cecil  
 City or town BAINBRIDGE MARYLAND  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 11 months  
 Hospital, institution, or street address where death occurred: US Naval Hospital, Nav Tra Cen B Bainbridge Maryland.  
 How long in hospital or institution? 1 day.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State TEXAS County Smith  
 City or town TYLER  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Route # 3  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war WORLD WAR II ✓

## 3. (a) FULL NAME

Luther (none) HARDEN

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male

Colored

Married

8. (b) Name of husband or wife Gladys Mae HARDENRoute # 3 Tyler Texas 6. (c) If alive, give age 1 years7. Birth date of deceased (mo., day, yr.) 12 November, 1916

8. AGE:	Years	Months	Days	If less than one day
	<u>28</u>	<u>4</u>	<u>19</u>	hrs. min.

9. Birthplace Arg., Texas  
(Town, county, and state)10. Usual occupation US Navy

11. Industry or business

12. Name Unknown13. Birthplace Unknown14. Maiden name Unknown15. Birthplace Unknown18. Informant US NAVAL HOSPITAL, NAV TRA CEN  
BAINBRIDGE MARYLAND.Address Removal  
(Burial, cremation, or removal. Which?) Date thereof April 3, 1945  
(month) (day) (year)Cemetery or crematory So. Tyler, Smith Co., Texas  
Location Lee a. Patterson18. Funeral director Perryville, Ind.  
Address19. April 3 19 45 James E. Laughlin  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1 April, 1945 19 at 9:40 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 31 March 19 45 to 1 April 19 45  
and that I last saw h. im alive on 1 April 19 45Immediate cause of death Acute diffuse peritonitis DURATION 56 hoursDue to Aspergillus not recovered

Due to

Other conditions Acute pneumonitis, right 12 hrs.

(Include pregnancy within 3 months of death)

Major findings of operations Early acute appendicitis found Date of op. 1 April 1945  
Autopsy results Diffuse Peritonitis - Acute pneumonitis  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Signature Asst. Surgeon M. D.  
Comd. (Inc) - U.S. N. R.23. SIGNATURE U.S. Naval Hospital M. D. or other  
Bainbridge, Md. Address Date signed 4/2/45

CERTIFICATE OF DEATH

NAME

DATE OF DEATH

AGE

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

TIME OF DEATH

RECEIVED  
APR 21 1945  
BUREAU V.I.

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46

## CERTIFICATE OF DEATH

03859

Reg. Dist. No. 9

## 1. PLACE OF DEATH:

County.....*Cecil*  
 City or town.....*Chesapeake City, RD*  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....*20 yrs*  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....*Maryland* County.....*Cecil*  
 City or town.....*Chesapeake City, RD*  
 (If outside city or town limits, write RURAL and give nearest town)

Street No.....  
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

*Clayton Johnson*

## 3. (b) Social Security Number

4. Sex

*Male*

5. Color or race

*White*

6.(a) Single, married, widowed, or divorced

*married*

6.(b) Name of husband or wife

*Bertha Johnson*

7. Birth date of deceased (mo., day, yr.)

*June 16 1878*

8. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

*66**9**29*

hrs.

min.

9. Birthplace

*Port Penn Newcastle, Delaware*  
(Town, county, and state)

10. Usual occupation

*Farmer*

11. Industry or business

MOTHER FATHER

12. Name

*Clarence Johnson*

13. Birthplace

*Delaware*

14. Maiden name

*Hennretta Sharp*

15. Birthplace

*Delaware*

16. Informant

*Mrs Bertha Johnson*

Address

*Chesapeake City Md*

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

*Apr 18 1945*  
(month) (day) (year)

Cemetery or crematory

*Bethel Cemetery*

Location

*Chesapeake City, Md RD*

18. Funeral director

*H W Pippin*

Address

*Elkton, Maryland*

19. (Date rec'd by registrar)

*April 18 1945*

1945

*Mrs Ralph D. Pippin*  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

*April*19*45* at..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*Nov*19*44*

to

*April 14 1945*

and that I last saw him alive on

*April 13*19*45*

Immediate cause of death

*Carcinoma of liver*

DURATION

*6 months*

Due to

Due to

Other conditions

*Chronic nephritis*

(Include pregnancy within 8 months of death)

*ulcer*

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

*Thos D. Pippin*M. D. *attest*

Address

*Chesapeake City, Md*

Date signed

*4/16/45*

CERTIFICATE OF DEATH

RECEIVED

APR 21 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03860

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

## 1. PLACE OF DEATH:

County CecilCity or town Perryville Rural  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CecilCity or town Perryville Rural  
(If outside city or town limits, write RURAL and give nearest town)Street No. Branchtown  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

William Martin Keesey

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

White

## 6.(a) Single, married, widowed, or divorced

Married6.(b) Name of husband or wife Alice Kornbarger Keesey7. Birth date of deceased (mo., day, yr.) Jan. 22, 1876

6.(c) If alive, give age years

8. AGE: Years 69 Months 2 Days 23 It less than one day  
hrs. min.9. Birthplace Columbia Pa.  
(Town, county, and state)10. Usual occupation Welder11. Industry or business Stove Foundry12. Name Charles H. Keesey13. Birthplace Columbia Pa.14. Maiden name Anna Martin15. Birthplace Bainbridge Pa.16. Informant Alice H. KeeseyAddress Perryville, Md.17. Rural Date thereof April 17, 45  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory St. MarksLocation Perryville, Rural, Md.18. Funeral director J. A. Patterson & SonAddress Perryville, Md.19. April 17, 1945 James E. Pugh  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

2D. DATE OF DEATH April 14 19 45, at 12:30 P. M.I CERTIFY that death occurred on the date above stated; that I attended deceased from April 8 19 45 to April 14 19 45and that I last saw him alive on April 14 19 45Immediate cause of death Cerebral thrombosis DURATION 6 da.

Due to

Due to

Other conditions Silicosis Q-fever

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. F. Magnaw M. D. or otherAddress Perryville, Md. Date signed 4/15/45

CERTIFICATE OF DEATH

RECEIVED  
APR 21 1945  
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age is shown on

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

03861

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

FILE NO. 905 JUN 8 1945

### 1. PLACE OF DEATH:

Cosely Fail

City or town Fail Hill  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Cecil

City or town Elkton Md. P. 7. 10.  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

Millie A Lewis

### 3. (b) Social Security Number

4. Sex

F

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

20 years married

6. (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.)

August 30 - 1904

8. AGE:

44 Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Ask Co. Md. Maryland  
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER  
MOTHER

12. Name

Emmer Kent

13. Birthplace

Ask Co. Md. Maryland

14. Maiden name

Emma O. Shome

15. Birthplace

Md. Maryland

16. Informant

Herman B. Lewis

Address

Elkton Md. P. 7. 10.

17.

Burial  
(Burial, cremation, or removal. Which?)

Date thereof

April 10 - 45  
(month) (day) (year)

Cemetery or crematory

Green Valley Cem

Location

Ask Co. Md. Maryland

18. Funeral director

E. Anson

Address

Frederick Md.

19.

April 10 1945  
(Date rec'd by registrar)

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### MEDICAL CERTIFICATION

20. DATE OF DEATH April 9 1945, at 9:45 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 3 1945, to April 9 1945

and that I last saw her alive on April 9 1945

Immediate cause of death

Lobar Pneumonia

DURATION

Due to

Septic sore throat

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. \_\_\_\_\_

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury

Injured at work?

23. SIGNATURE

Beckwith - M. D.

M. D. or other

Address

Cecil Md

Date signed 4/9/45

Registrar

RECEIVED

APR 13 1945

RECEIVED  
APR 13 1945  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 440

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

## 1. PLACE OF DEATH:

County..... Cecil  
 City or town..... Bainbridge, Maryland.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 1 month & 3 days  
 Hospital, institution, or street address where death occurred..... US Naval Hospital  
Naval Training Center, Bainbridge, Maryland.  
 How long in hospital or institution?..... 3 days.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Louisiana..... Parish of Caddo  
 City or town..... Delhi  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. .... Route # 3, Box 59  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war..... WORLD WAR II ✓

## 3. (a) FULL NAME

Andrew (None) Mc DOWELL

## 3. (b) Social Security Number

4. Sex..... Male  
 5. Color or race..... Colored  
 6.(a) Single, married, widowed, or divorced..... SINGLE

6.(b) Name of husband or wife..... Not married

7. Birth date of deceased (mo., day, yr.)..... 8/12/26  
 6.(c) If alive, give age..... years

8. AGE: Years..... 18 Months..... 7 Days..... 29  
 If less than one day..... hrs. .... min.

8. Birthplace..... Delhi, Parrish of Caddo, La.  
(Town, county, and state)10. Usual occupation..... US NAVY

11. Industry or business

12. Name..... Alvin McDowell13. Birthplace..... Unknown14. Maiden name..... Unknown15. Birthplace..... Unknown16. Informant..... US NAVAL HOSPITAL, NAV TRA CENAddress..... BAINBRIDGE MARYLAND.

17. Removal Date thereof..... April 17, 1945  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... To Delhi, LouisianaLocation..... Delhi, Louisiana18. Funeral director..... Lee a. Patterson & Son.Address..... Perryville, Md.

19. April 17 1945 Irma E. Daugherty  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 11, 1945 19..... at 1120 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
8 April, 1945, to 11 April, 1945  
 and that I last saw him alive on 11 April, 1945.

Immediate cause of death..... ASPHYXIA  
 DURATION..... 5 min.

Due to..... Pharyngitis, acute (obstructive)..... 6 days.

Due to.....

Other conditions..... Mumps..... 6 days.

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results..... Confirmed above diagnoses.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... E.M. HAUGRUD, MD

US NavHosp NavTraCen M. D. or other

Address..... Bainbridge, Md. Date signed..... 4/11/45.

CERTIFICATE OF DEATH

RECEIVED  
APR 21 1945  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

## CERTIFICATE OF DEATH

03863

Reg. Dist. No. 96

## 1. PLACE OF DEATH:

County CecilCity or town Perry Point, Md.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 16 yrs. 8 mo. 19 da.

Hospital, institution, or street address where death occurred:

Veterans Administration, Perry Point, Md.How long in hospital or institution? Same as above

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State West Virginia County HarrisonCity or town Bridgeport  
(If outside city or town limits, write RURAL and give nearest town)Street No. Rt. #2  
(If rural, give LOCATION)

2.(a) If veteran, name war

WW I

## 3. (a) FULL NAME

MARTIN, James T.

## 3. (b) Social Security Number

-

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Widower

## 6. (b) Name of husband or wife

Unknown6. (c) If alive, give age. - years7. Birth date of deceased (mo., day, yr.) October 2, 18958. AGE: Years 49 Months 6 Days 3 If less than one day  
- hrs. - min.9. Birthplace West Virginia  
(Town, county, and state)

## 10. Usual occupation

Farmer

## 11. Industry or business

12. Name A. M. Martin13. Birthplace West Virginia14. Maiden name Mary A. Carter15. Birthplace West Virginia16. Informant Hospital RecordsAddress Veterans Administration, Perry Point, Md.17. Removal Date thereof 4-5-45  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Bendium CemeteryLocation Bridgeport, W. Va.18. Funeral director Pennington & Son  
Address Navre de grace, Md.19. April 5 19 45 James E. Smyth  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 5 19 45 at 4:55A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 17 19 28, to April 5 19 45  
and that I last saw him alive on April 5 19 45Immediate cause of death Tuberculosis, pulmonary, chronic,  
far advanced, active DURATION 1 yr. 9 mo.

Due to

Due to

Other conditions Dementia Precox, Hebephrenic  
16 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations - Date of op. -Autopsy results Not performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide - Date of -Where did injury occur? - (City or town) (County) (State)Injured at home, farm, industry, public place (where?) -Means of injury - Injured at work? -23. SIGNATURE E. TROLLINGER, Lt. Col., M.C. M. D. or other  
Clinical Director Date signed 4-5-45

RECEIVED  
APR 24 1945  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30

## CERTIFICATE OF DEATH

03864

Reg. Dist. No. 96

## 1. PLACE OF DEATH:

County..... Cecil  
 City or town..... Veterans Administration, Perry Point, Md.  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month 4 days

Hospital, institution, or street address where death occurred:

Veterans Administration, Perry Point, Md.

How long in hospital or institution? Same as above

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Pennsylvania County..... York

City or town..... Hanover  
 (If outside city or town limits, write RURAL and give nearest town)Street No..... 145 Carlisle St.  
 (If rural, give LOCATION)

2.(a) If veteran, name war..... WW II

## 3. (a) FULL NAME

MILLER, Charles S.

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife..... Kathleen A. Croft

B. (c) If alive, give age 27 years

7. Birth date of

deceased (mo., day, yr.) April 23, 1912

8. AGE:

Years

Months

Days

If less than one day

32

11

23

hrs.

min.

9. Birthplace..... Springs Grove, Pa.

(Town, county, and state)

10. Usual occupation..... Laborer

11. Industry or business.....

FATHER

12. Name..... Charles H. Miller

13. Birthplace..... Springs Grove, Pa.

MOTHER

14. Maiden name..... Mary Eppley

15. Birthplace..... York, Pa.

16. Informant..... Hospital Records

Address..... Veterans Administration, Perry Point,

17. Removal Date thereof 4-18-45 Md.  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Baltimore National Cemetery

Location..... Baltimore, Md.

18. Funeral director..... Pennington &amp; Son

Address..... Pennington &amp; Son, Navy de Grace, Md.

19. April 18, 45 - Dr. E. F. Dougherty  
 (Date rec'd by Registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 14, 1945, at 11:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 10, 1945, to April 14, 1945

and that I last saw him alive on April 14, 1945

Immediate cause of death.....

Syphilis of the Central Nervous

System, Meningo-Encephalic

Type

Due to.....

Due to.....

DURATION

Over

6 months

Other conditions..... Psychosis with syphilis of 6 months

Central Nervous System, Meningo-Encephalic Type.  
 (Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results..... Not performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....  
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE

E. F. Dougherty, Lt. Col., M.C. &amp; M.D. or other

Veterans Administration, Perry Point, Md.  
 Address..... Date signed..... 4-18-45

DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED  
APR 21 1945  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

186-A

03865

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH: Cecil  
County...  
City or town... Elletts Rural  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? all life  
Hospital, institution, or street address where death occurred:  
Union Hosp. Elletts Md.  
How long in hospital or institution? 10 hours

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
Md. Cecil  
State... County...  
City or town... Elletts Rural  
(If outside city or town limits, write RURAL and give nearest town)  
Street No...  
(If rural, give LOCATION)  
2(a) If veteran, name war...

## 3. (a) FULL NAME

Emma Ellen Price

## 3. (b) Social Security Number

None

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed  
6. (b) Name of husband or wife John Price  
6. (c) If alive, give age... years  
7. Birth date of deceased (mo., day, yr.) May 21, 1866  
8. AGE: Years 78 Months 10 Days 27 If less than one day hrs. min.

9. Birthplace Cecil Co. Md.  
(Town, county, and state)  
10. Usual occupation House wife  
11. Industry or business Home  
12. Name Thomas Reed  
13. Birthplace Cecil Co. Md.  
14. Maiden name Rachel R. Harris  
15. Birthplace Cecil Co. Md.

16. Informant Mrs Annie Corriden  
Address Elletts, Md.  
17. Burial Date thereof Apr. 21, 1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Cherry Hill  
Location Elletts Md. R.F.D.  
18. Funeral director Ralph M Reed  
Address Rising Sun, Md.  
19. April 20 1945  
(Date rec'd by registrar) JH Frager Registrar

## MEDICAL CERTIFICATION

2D. DATE OF DEATH 4-17 1945 at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... to 19...

and that I last saw him... alive on 19...

Immediate cause of death... Compound Fracture of skull  
Due to...  
Due to...  
Other conditions...  
(Include pregnancy within 3 months of death)

## DURATION

Major findings of operations...

Date of op. ...

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 4-16-45

Where did injury occur? Elletts Cecil Md.  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury Fell down stairs Injured at work?

23. SIGNATURE

R L Dodson M.D. Cecil County  
Address Rising Sun, Md. 2420-45  
Date signed

Medical Examiner Cecil County

RECEIVED  
APR 25 1945  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 78-2

03866

## CERTIFICATE OF DEATH

Reg. Diat. No. 92

## 1. PLACE OF DEATH:

County... Cecil

City or town... Elkton  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? February 14, 1945

Hospital, institution, or street address where death occurred:

Union Hospital, Elkton, Maryland

How long in hospital or institution? 2 mons. 12 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Cecil

City or town... Elkton  
(If outside city or town limits, write RURAL and give nearest town)Street No. ....  
(If rural, give LOCATION)

2.(a) If veteran, name war .....

## 3.(a) FULL NAME

Mary Etta Reynolds

## 3.(b) Social Security Number

4. Sex Female	5. Color or race White	6.(a) Single, married, widowed, or divorced Widow
------------------	---------------------------	--

6.(b) Name of husband or wife... John Phillip Reynolds

7. Birth date of deceased (mo., day, yr.) No Inf.

6.(c) If alive, give age ..... years

8. AGE: Years	Months	Days	If less than one day
About 75 yrs.			.....hrs. ....min.

9. Birthplace... Cecil Co.  
(Town, county, and state)

10. Usual occupation... Housework

## 11. Industry or business

12. Name... John Simmons

13. Birthplace... England

14. Maternal name... Wilhelmina Ash

15. Birthplace... Cecil County

18. Informant... Mrs. Otis Kline - daughter

Address South Street, Elkton, Maryland

17. Burial Date thereof Apr 29/45  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory... Elkton

Location... Elkton, Md.

18. Funeral director... H. W. Pappas

Address... Elkton, Md.

19. April 28, 1945  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... April 26, 1945, at 4 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 1, 1945, to April 26, 1945, and that I last saw him alive on April 25, 1945.

Immediate cause of death... Chronic myocarditis arteriosclerosis

DURATION... unknown

Due to .....

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. ....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... F. H. McHugh M.D.

M. D. or other

Address... Elkton, Maryland Date signed 4-27-45

RECEIVED

MAY 2 1945

BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 3-2

## CERTIFICATE OF DEATH

Reg. Dist. No. 03867 26

## 1. PLACE OF DEATH:

County Cecil  
 City or town Perry Point, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 17 yrs. 9 mo. 27 da.  
 Hospital, institution, or street address where death occurred:  
Veterans Administration, Perry Point, Md.  
 How long in hospital or institution? 17 yrs. 9 mo. 27 da.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Penna. County Greene  
 City or town Waynesburg,  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war. WW I

## 3. (a) FULL NAME

RHOADES, Spencer

## 3. (b) Social Security Number

-

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Single

## 8. (b) Name of husband or wife

6. (c) If alive, give age. \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) April ? , 1897

## 8. AGE:

48

Years

-

Months

Days

If less than one day

-

hrs.

-

min.

## 9. Birthplace

Pennsylvania

(Town, county, and state)

## 10. Usual occupation

Mechanic, automobile

## 11. Industry or business

## FATHER

## 12. Name

Levi Rhoades

## 13. Birthplace

Virginia

## MOTHER

## 14. Maiden name

Elizabeth Anderson

## 15. Birthplace

Pennsylvania

## 16. Informant

Hospital Records

## Address

Perry Point, Md.

## 17. Removal

(Burial, cremation, or removal. Which?)

Date thereof April 27, 1945

(month) (day) (year)

## Cemetery or crematory

Oakmont Cemetery

## Location

Waynesburg, Pa.

## 18. Funeral director

Pennington & Son, Revie de Grace, Md.

## Address

19. April 27, 1945  
 (Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 25 1945 at 3:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

XXXXXX June 29 1927 to April 25 1945

and that I last saw him alive on April 25 1945

## Immediate cause of death

Syphilis of the Central Nervous System, Meningo-encephalitic type

## DURATION

Over 17

## Due to

Yrs.

## Due to

Other conditions Psychosis with Syphilis of the Central Nervous System, Meningo-encephalitic type.

Over 17Yrs.

## Major findings of operations

Date of op. \_\_\_\_\_

## Autopsy results

Not performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

## 23. SIGNATURE

A. E. Hollinger  
A. E. Hollinger, Lt. Col., U.S. Army  
 Clinical Director  
 Address Perry Point, Md. Date signed 4-27-45

RECEIVED  
MAY 1 1945  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-7)

03868

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

## 1. PLACE OF DEATH:

County Cecil  
 City or town Perry Point, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 6 yrs. 7 mos. 3 days  
 Hospital, institution, or street address where death occurred:  
Veterans Administration, Perry Point, Md.  
 How long in hospital or institution? 6 yrs. 7 mos. 3 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Delaware County Newcastle  
 City or town Wilmington  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1005 Tatnall St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war Spanish-American ✓

## 3. (a) FULL NAME

SASSE, George W.

## 3. (b) Social Security Number

Unknown

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Mrs. Ella L. Sasse6. (c) If alive, give age 74 years7. Birth date of deceased (mo., day, yr.) November 19, 1860

8. AGE: Years 84 Months 5 Days 2 If less than one day  
 hrs. min.

9. Birthplace Wilmington, Delaware  
(Town, county, and state)10. Usual occupation Letter Carrier11. Industry or business U.S. Govt.12. Name John C. Sasse13. Birthplace Unknown14. Maiden name Mary Ostermuhl15. Birthplace Unknown16. Informant Records - Veterans Administration,Address Perry Point, Md.17. Removal April 21, 1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Riverview Cemetery,Location Wilmington, Delaware18. Funeral director H. W. Pippin  
H. W. PIPPINAddress 259 E. Main St., Elkton, Md.19. April 21 19 45 Irvin E. Daugherty  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 21 19 45 at 12:40 A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
September 18, 19 38, to April 21 19 45and that I last saw him alive on April 21 19 45Immediate cause of death Cerebral Hemorrhage DURATION 5 daysDue to Cerebral Arteriosclerosis 6 1/2 yrs.

Due to

Other conditions Psychosis, senile, simple deterioration 6 1/2 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide no Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE A. E. Trollinger  
A. E. TROLLINGER, Lt. Col., M.C. Vol. Medical DirectorAddress VAH, Perry Point, Md. Date signed 4-21-45

RECEIVED  
APR 23 1945  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (85)

## CERTIFICATE OF DEATH

03869

Reg. Dist. No. 92

## 1. PLACE OF DEATH:

County..... Cecil  
 City or town..... Elkton  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... Since April 21  
 Hospital, institution, or street address where death occurred:  
 Union Hospital  
 How long in hospital or institution?..... two days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md..... County..... Cecil  
 City or town..... Elkton Md  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... 334 W. Main St  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Joseph Scotsa

## 3. (b) Social Security Number

4. Sex..... Male  
 5. Color or race..... White  
 6.(a) Single, married, widowed, or divorced..... Married

6.(b) Name of husband or wife..... Valentine Scotsa

6.(c) If alive, give age..... 50 years  
 7. Birth date of deceased (mo., day, yr.)..... Aug. 5, 1892

8. AGE: Years..... 52 Months..... 8 Days..... 16  
 It less than one day..... hrs..... min.

9. Birthplace..... Italy  
 (Town, county, and state)

10. Usual occupation..... Mechanic

11. Industry or business.....

12. Name..... Paolo Scotsa

13. Birthplace..... Italy

14. Maiden name..... Amelia Macchia

15. Birthplace..... Italy

16. Informant..... Valentine Scotsa

Address..... 334 W. Main St Elkton, Md

17. Burial..... Date thereof..... April 27, 1945

(Burial, cremation, or removal, Which?)..... (month) (day) (year)

Cemetery or crematory..... Holy Cross

Location..... Del Co. Phila. Pa

18. Funeral director..... J. W. Lippert

Address..... Elkton, Md

April 24, 1945

(Date rec'd by registrar)..... F. F. Frazer

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... 4-23-1945 at 6:45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-23-1945 to 4-23-1945  
 and that I last saw him alive on 4-23-1945

Immediate cause of death.....  
 DURATION..... About 10 3/4 hrs

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... J. W. Lippert

M. D. or other

Address..... Date signed.....

CERTIFICATE OF DEATH

RECEIVED

MAY 2 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (462)

03870

## CERTIFICATE OF DEATH

Reg. Diat. No. 96

## 1. PLACE OF DEATH:

County Cecil  
 City or town VETERANS ADMINISTRATION, PERRY POINT, MD  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 yrs. 1 da.Hospital, institution, or street address where death occurred:  
Veterans Administration, Perry Point, Md.How long in hospital or institution? Same as above

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State District of Columbia County Washington, D.C.  
 City or town 4503 Conduit Road  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 4503 Conduit Road  
 (If rural, give LOCATION)

2.(a) If veteran, name war WW I ✓

## 3. (a) FULL NAME

SERRIN, William L.

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife Single

7. Birth date of deceased (mo., day, yr.) May 28, 1888 6.(c) If alive, give age - years

8. AGE: Years 56 Months 10 Days 19 It less than one day - hrs. - min.

9. Birthplace Washington, D.C.  
 (Town, county, and state)

10. Usual occupation Unknown11. Industry or business -12. Name Unknown13. Birthplace Unknown14. Maiden name Unknown15. Birthplace Unknown

16. Informant Hospital Records  
Veterans Administration, Perry Point, Md.  
 Address

17. Removal Date thereof 4-18-45  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Arlington National Cemetery  
Arlington, Va.  
 Location

18. Funeral director Pennington & Son  
Pennington & Son  
 Address Havre de Grace, Md.

19. April 18 19 45 Irma E. Daugherty  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 16 19 45 at 4:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 15 19 31 to April 16 19 45

and that I last saw him alive on April 16 19 45Immediate cause of death Tumor of Intestines DURATION Undeter-Adenocarcinoma of ileum, near junctionDue to tion with ascending colonWith metastases. CUPPDue to -Other conditions Dementia Precox, Heberpneictype 30 years

(Include pregnancy within 3 months of death)

Major findings of operations -Date of op. -Autopsy results Above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide - Date of -

Where did injury occur? - (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -Means of injury - Injured at work? -23. SIGNATURE J. E. Hollinger

Lt. Col., U.S. Army, Veterans Administration

Address Perry Point, Md. Date signed 4-18-45

CERTIFICATE OF DEATH

U. S. BUREAU OF HEALTH

U. S. DEPARTMENT OF HEALTH

U. S. BUREAU OF HEALTH

RECEIVED  
APR 21 1945  
BUREAU V.I.E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

03871

Reg. Dist. No. 96

## 1. PLACE OF DEATH:

County Cecil  
 City or town Veterans Administration, Perry Point, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 4 mo. 1 da.  
 Hospital, institution, or street address where death occurred:  
Veterans Administration, Perry Point, Md.  
 How long in hospital or institution? 4 months 1 da.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Pennsylvania County Allegheny  
 City or town Pittsburgh  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1008 Western Avenue  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war W.W.I. ✓

## 3. (a) FULL NAME

SLOWIKOWSKI, Mike

## 3. (b) Social Security Number

-

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married

## MEDICAL CERTIFICATION

2D. DATE OF DEATH April 22 1945 at 2:13 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

December 21 1944 to April 22 1945and that I last saw him alive on April 22 1945Immediate cause of death Myocardial Insufficiency DURATION Over 2 monthsDue to Syphilis Over 6 monthsDue to Psychosis withOther conditions Syphilis of Central NervousSystem, Meningo-encephalitic type Over 6 mo.

(Include pregnancy within 3 months of death)

Major findings of operations -Date of op. -Autopsy results Not performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide - Date of -Where did injury occur? - (City or town) (County) (State)Injured at home, farm, industry, public place (where?) -Means of injury - Injured at work? -23. SIGNATURE A.E. TreloarTRELOAR, Lt. Col., M.C., Chief Medical DirectorAddress Veterans Administration Date signed 4-23-456. (b) Name of husband or wife Bertha SlowikowskiMaiden name unknown 6. (c) If alive, give age Unknown years7. Birth date of deceased (mo., day, yr.) August 10, 1892

8. AGE:	Years	Months	Days	If less than one day
	<u>52</u>	<u>8</u>	<u>12</u>	<u>-</u> hrs. <u>-</u> min.

9. Birthplace Russia  
(Town, county, and state)10. Usual occupation Railway equipment repairmen11. Industry or business -FATHER 12. Name John Slowikowski13. Birthplace UnknownMOTHER 14. Maiden name Katherine-Unknown15. Birthplace Unknown16. Informant Hospital RecordsAddress Veterans Administration, Perry Point, Md.17. Removal 4-23-45

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Uniondale CemeteryLocation Pittsburgh, Pa.18. Funeral director Pennington & Son, Havre de Grace, Md.Address -19. April 23 1945 Irma E. Roughton

(Date rec'd by registrar) Registrar

RECEIVED

APR 25 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 150

## CERTIFICATE OF DEATH

Reg. Dist. No. 03872 91

## 1. PLACE OF DEATH:

County... *Elkton Rural*  
 City or town... *Elkton Rural*  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?... *6 hours*  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?...

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State... *Del.* County... *New Castle*  
 City or town... *Milington*  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No... *1401 Woodlawn Dr.*  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war...

## 3. (a) FULL NAME

*George Heale Spence*

## 3. (b) Social Security Number

4. Sex... *M.* 5. Color or race... *White* 6.(a) Single, married, widowed, or divorced... *Married*

6.(b) Name of husband or wife... *Berulah Spence*

6.(c) If alive, give age... *37* years  
 7. Birth date of deceased (mo., day, yr.)... *Nov. 12 1907*

8. AGE: Years... *37* Months... *4* Days... *20* If less than one day... hrs. min.

9. Birthplace... *Milington Del.*  
(Town, county, and state)10. Usual occupation... *Plumber*11. Industry or business... *Plumbing*12. Name... *Preston W Spence*13. Birthplace... *Curry Hill Md.*14. Maiden name... *Jennie Lane*15. Birthplace... *Baker Del.*16. Informant... *Jessie Preston W Spence*Address... *1407 Hamleton St Milington*17. *Burial* Date thereof... *Apr 25 45*  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory... *Mt Salem*Location... *Wilmington Del*18. Funeral director... *H W Tappin*Address... *Elkton, Md.*19. *April 23rd* 19 *45* *Wm Ralph D. Spence*  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... *April 22* 19 *45* *2:45 PM*

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from... 19... to... 19...

and that I last saw h... alive on... 19...

Immediate cause of death... *Choked body*

Due to...

Due to...

Other conditions...

(Include pregnancy within 3 months of death)

Major findings of operations...

Date of op. ...

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... *Accident* Date of... *4/22-45*Where did injury occur? *Elkton New Castle Md.*  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) *Home*Means of injury *House burned* Injured at work?

Medical Examiner

for Cecil County

M. D. or other

23. SIGNATURE... *Wm Ralph D. Spence* Date signed... *4/22-45*Address... *Elkton Md.*

RECEIVED

APR 26 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03873

## CERTIFICATE OF DEATH

Reg. Dist. No. 91

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19 45

James Wilson Spence

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

April 22

19 45

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

18.

to

19.

and that I last saw him alive on

19.

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

CERTIFICATE OF DEATH

JUDICIAL DEPARTMENT OF MARYLAND

STATE OF MARYLAND

RESIDENCE OF DECEASED

RECEIVED  
APR 26 1945  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

03874

96

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County..... Cecil  
 City or town..... Port Deposit Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 20 years.  
 Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... MD County..... Cecil  
 City or town..... Port Deposit Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Elizabeth Stewart

## 3. (b) Social Security Number

4. Sex..... Female 5. Color or race..... Colored 6.(a) Single, married, widowed, or divorced..... Widowed  
 6.(b) Name of husband or wife..... Enoch Stewart  
 deceased..... 6.(c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.)..... Oct. 3. unknown  
 8. AGE: Years..... About 58 Months..... Days..... If less than one day..... hrs. .... min.

9. Birthplace..... Anne Arundelles, Md  
 (Town, county, and state)

10. Usual occupation..... House work

## 11. Industry or business

12. Name..... Alfred Halliday  
 13. Birthplace..... Anne Arundelles, Md.

14. Maiden name..... unknown

15. Birthplace.....

16. Informant..... Carrie Clark  
 Address..... Port Deposit, Md.

17. Burial Date thereof..... April 29 1945  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Cokebury

Location..... Port Deposit Md. Rural

18. Funeral director..... W. A. Patterson & Son

Address..... Curryville, Md.

19. April 29, 1945 Irma Edgington  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 27 1945, at 6:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 24, 1945 to April 27, 1945 and that I last saw her alive on April 27, 1945

Immediate cause of death.....

Acute myocarditis DURATION 1-27-45

Due to.....

Due to.....

Due to.....

Other conditions..... Pastor's files 3-24-45

(Include pregnancy within 3 months of death)

Major findings of operations.....

.....Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury..... Injured at work? .....

13. SIGNATURE..... Claude L. Brown M.D.

Address..... Port Deposit Md. Date signed..... 4-28-45

RECEIVED

MAY 1 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03875

## CERTIFICATE OF DEATH

Reg. Dist. No. 91

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long to hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (q) Single, married, widowed, or divorced

6. (b) Name of husband or wife

8. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hrs.

mo.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19.

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## MEDICAL CERTIFICATION

20. DATE OF DEATH

19. 45- at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw him alive on 19.

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Medical Examiner

for Cecil County

M. D. or other

Address

Date signed 4-7-45

CERTIFICATE OF DEATH

RECEIVED  
APR 21 1945  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age is shown on

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03876

## CERTIFICATE OF DEATH

Reg. Dist. No. 94

FILM No. G 95 MAY 29 1945

### 1. PLACE OF DEATH:

County Charles  
City or town Charlestown  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 4 months  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Del County New Castle  
City or town Wilmington  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)  
2. (a) If veteran, name war not a veteran ✓

### 3. (a) FULL NAME

Lillian S. Woodward

### 3. (b) Social Security Number

none

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widower

8. (b) Name of husband or wife Isaella

7. Birth date of deceased (mo., day, yr.) Dec 7 1865 6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 80 Months 4 Days 13 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Del  
(Town, county, and state)

10. Usual occupation Myocarditis

11. Industry or business Retired - 30 yrs

12. Name Aaron Woodward

13. Birthplace Del

14. Maiden name Stidham

15. Birthplace Del

16. Informant Mrs Mary Moore

Address Charlestown, Md

17. (Burial, cremation, or removal, Which?) Burial Date thereof Apr 23-45  
(month) (day) (year)

Cemetery or crematory Brandywine

Location Wil Del

18. Funeral director Joe R. Evans

Address North East, Md.

19. 4/19 - 19 45 Lidia V. Owens  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Apr - 19 19 45 at 11:5 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from men 14 19 45 to Apr 19 19 45

and that I last saw him live on Apr - 18 19 45

Immediate cause of death myocarditis DURATION 2 yrs.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE C. B. Collins M. D. or other

Address North East Md. Date signed 4-19-45

CERTIFICATE OF DEATH

IN THE CITY OF BOSTON

RECEIVED  
APR 21 1945  
BUREAU V.B.